

## **SUPPLEMENTAL HEALTH CARE PROGRAM IMPLEMENTATION GUIDELINES**

### **I. General.**

Effective 1 October 1999, the revised Supplemental Health Care Program will be implemented. Referral and claims payment responsibility will be transferred to the Managed Care Support Contractors (MCSCs). The revised claims payment process applies to inpatient and outpatient medical claims submitted to MCSCs by civilian institutions, individual professional providers, resource sharing providers, MTFs, suppliers, pharmacies and uniformed service members for civilian healthcare received within the 50 United States and the District of Columbia. This process applies to all claims received on or after October 1, 1999. The following guidelines are provided to ensure appropriate application of Defense Health Program/Military Health System policy and to optimize the managed care aspects of the TRICARE Program, including the use of Designated Providers. Claims for care provided to TRICARE Prime Remote enrollees are not covered by the revised Supplemental Health Care Program (instead, see OPM, Part 3, Chapter 8).

### **II. Supplemental Health Care Defined**

- A. Supplemental Health Care refers to medical care received by Active Duty Service Members (ADSMs) of the Uniformed Services and other designated patients pursuant to an MTF referral (**MTF Referred Care**). The responsibility for clinical management of these patients remains with the MTF.
- B. Supplemental Health Care also includes specific episodes of ADSM non-MTF referred civilian care, both emergent and authorized non-emergent care (**SPOC-Authorized Care**). Eligible members may include members in travel status, Navy/Marine Corps service members enrolled to deployable units and referred by the unit PCM (Non-MTF provider), eligible Reserve Component personnel, ROTC students, cadets/midshipmen, and eligible foreign military. Categories of care may include emergency care, authorized non-emergent care and related pharmacy services. Non-emergent care must be authorized by the SPOC. The MCSC's Health Care Finder (HCF) will assist with referrals to network providers, where available. If a network provider is not available, the referral will be made to a TRICARE-authorized provider. If no authorization is on file for non-emergent claims received by the MCSC, the claim will be held pending determination by the SPOC.
- C. Attachment 1, Supplemental Care Matrix, describes the payment methodology and applicable copayments, if any, for beneficiary categories and care delivery sites. Attachment 2 includes flow chart diagrams for the Supplemental Care program.
- D. Claims for covered dental services rendered to ADSMs, including adjunctive dental care, shall be forwarded to the appropriate SPOC for processing and payment by

the Military Medical Support Office (MMSO) in accordance with OPM, Chapter 9, Addendum B).

- E. When care in the MTF, including resource sharing providers, is not available, the Health Care Finder (HCF) shall refer care to network providers. In all cases referrals shall meet TRICARE Prime standards for travel, access, and waiting times (unless waived by the beneficiary). The MCSCs shall provide payment for inpatient and outpatient services, including authorized pharmacy services, in accordance with the claims processing requirements outlined in OPM, Part Three, Chapter 9. The HCF shall also notify the provider that all MTF-referred claims are to be forwarded to the regional MCSC for processing and payment.

### **III. Provider Reimbursement for Supplemental Care Claims**

Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim (e.g., DRGs, mental health per diem, CMAC, or TRICARE network provider discount). Reimbursement for services authorized but not ordinarily covered by TRICARE and/or rendered by a non-authorized provider will be reimbursed on a billed charge basis.

***Uniformed service members who have acted in apparent good faith shall not be required to incur out of pocket expenses or be subjected to ongoing collection initiated by a provider who has refused to abide by TRICARE requirements. In these situations, the MCSC, or the uniformed service member, shall notify the SPOC for appropriate action.***

### **IV. Contractor Reimbursement for Supplemental Health Care Claims Paid**

For MTF-referred care in Regions 1, 2, and 5, MCSCs will bill the referring MTF on a monthly basis. For all other regions the MCS Contractor will be reimbursed for MTF-referred care through the TRICARE Management Activity, Aurora, CO. For non-MTF-referred care (emergent and SPOC authorized non-emergent care) the MCS Contractor will be reimbursed through the TRICARE Management Activity, Aurora, CO.

### **V. Referrals to VA/Designated Providers**

A. Claims from referrals to VA facilities that participate in the contractor's preferred provider network will be sent by the VA to the regional contractor's claims processor. If a referral is made to a VA that does not participate in the network, but does have a Service/VA Sharing agreement, the claim will be returned to the Service's MTF for payment. The Services or Lead Agents should request TMA Executive Director guidance on any sharing arrangements not addressed in these instructions.

B. The provisions of the revised Supplemental Health Care Program will not apply to services furnished by a Designated Provider (formerly a Uniformed Services Treatment Facility) if the services are included as covered services under the current negotiated agreement between the USTF and the ASD(HA). However, any services not included

in the current designated provider agreement shall be paid by the MCS Contractor in accordance with the requirements in OPM Part Three, Chapter 9.

## **VI. Fiscal Year 99 – 00 Transition Plan**

A. Beginning 1 October 1999, the managed care support contractors (MCSCs) will assume responsibility for processing and paying all supplemental health care claims. Special instructions for transition of claims in Region 1, 2 and 5 are set forth at the end of this document.

1. Health care claims for care delivered prior to October 1, 1999 but received by MTFs after October 1, 1999 should be submitted to the MCSC claims processor for payment.
2. If a claim arrives at the MCSC for pricing prior to September 27, 1999, the MCSC will price the claim and return it to the MTF for payment. If a claim has been priced, the MTF will pay the claim (regardless of when they receive the pricing back from the MCSC).
3. For claims processed by the MCSC on or after October 1, 1999 for care delivered before October 1, 1999, the MCSC regional claims processors will ensure that the claim has not already been priced and returned to the MTF. If the claim had been previously priced, the current claim will be denied by the MCSC as a duplicate.
4. For claims processed by the MCSC on or after October 1, 1999 for care delivered before October 1, 1999, the Services and their MTFs are responsible for retroactively reviewing the claims payments to ensure (a) the care was authorized; and (b) there was no duplicate payment made by the MTF for the care. The MCSCs will produce detailed reports that MTFs are obligated to review.
5. If an MTF identifies a duplicate payment, the MTF is responsible for contacting the provider (or beneficiary) and initiating recoupment action.
6. For claims for care which overlap FY 99 and FY 00 dates of service, the MCSC claims processor will pay the claim. MTFs should call the regional HCF to ensure authorization is on file. If no authorization is on file, the case will be forwarded to the MMSO for "fitness for duty" determination.

B. Transition of payment rules for the "Interim" Active Duty claims processing project in Regions 1, 2 and 5:

1. Beginning September 27, claims received for patients residing outside the Regions will be forwarded to the appropriate contractor as out-of-jurisdiction claims.

2. No transmission of denied claims to MMSO will take place after September 20.
3. Claims processed to denial September 20 through 30 will be identified by ICN Julian date and transmitted to MMSO on or after October 1, with the 48-hour turnaround rules in effect.
4. Any outstanding diskette transmissions will be worked to completion based on the response received from MMSO.

## **VII. Points of Contact**

### **A. Military Medical Support Office, Great Lakes, IL.**

Mailing Address for SPOC Authorized and emergent care claims:  
Military Medical Support Office  
PO Box 886999  
Great Lakes, IL 60088-6999

Customer Service (including dental claims): 1-888-MHS-MMSO  
(1-888-647-6676)

MMSO Web Page: <http://navymedicine.med.navy.mil/mmso>

### **B. Public Health Service/National Oceanographic and Atmospheric Administration (PHS/NOAA)**

PHS/NOAA Point of Contact:  
Medical Affairs Branch  
Beneficiary Medical Program  
5600 Fishers Lane, Room 4C-06  
Rockville, MD 20857  
Commercial Telephone Number: (800) 368-2777  
Fax: (800) 733-1303